

Table 1 Logistic regression model evaluating predictors of absence of left ventricular recovery

	Univariate analysis (OR (95% CI))	p Value
Peak CK-MB*	1.007 (1.002 to 1.012)	0.01
Q waves	2.2 (1.2 to 3.8)	0.007
MBG	0.45 (0.26 to 0.85)	0.01
Visual MCE	0.113 (0.02 to 0.52)	0.005
Quantitative MCE*	0.002 (0.0005 to 0.04)	0.0005

*Independent predictor in multivariate analysis.

CI, confidence interval; CK, creatine kinase; MBG, myocardial blush grade; MCE, myocardial contrast echocardiography; OR, odds ratio.

In our opinion, the improvement in diagnostic accuracy obtained with quantitative MCE is based on a better assessment of myocardial blood flow. Visual MCE analysis relies on MCE peak signal intensity assessment (A) but does not take into account the other component of myocardial blood flow (blood velocity). Quantitative analysis can estimate blood velocity through the rate of rise of signal intensity and therefore provide a true MCE derived myocardial blood flow index.⁵ This technique can therefore improve diagnosis of microvascular dysfunction and risk stratification of patients with AMI.

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The Ethics Committee for Clinical Studies of Hospital Gregorio Marañón approved the study.

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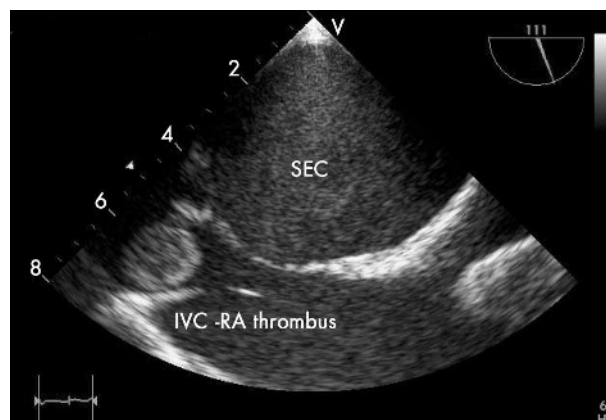
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IMAGES IN CARDIOLOGY

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Thrombus at the junction of the inferior vena cava and right atrium: a contraindication for transfemoral percutaneous mitral commissurotomy

A 37 year old woman, with severe rheumatic mitral stenosis, chronic atrial fibrillation (AF) and a history of recurrent strokes, presented with troponin T positive unstable angina. She was on long term oral anticoagulants and had an international normalised ratio (INR) within target range. An angiogram showed normal coronary arteries. Percutaneous mitral commissurotomy (PTMC) was planned, as the valve was found pliable on transthoracic echocardiography. Transoesophageal echocardiography revealed dense spontaneous echo contrast, but no clot in the left atrium. An 18 × 16 mm thrombus was seen at the entry of the inferior vena cava (IVC) to the right atrium (RA). The thrombus was presumably related to the AF, as there was no deep vein thrombosis or any other evident thrombophilic states. Transjugular PTMC was not planned due to lack of previous experience in the centre. An elective mitral valve replacement and clot removal from the inferior vena cava was done under circulatory arrest. The IVC-RA junction can be an uncommon site of isolated thrombus in rheumatic patients with AF, and can hinder a successful transfemoral PTMC in an otherwise pliable mitral valve.



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